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The potential of social enterprise to enhance health and wellbeing: a model and systematic review

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Research Highlights

- Identifies/synthesises social enterprise activity on health and well-being
- Presents a potential conceptual model to aid understanding of pathways to impact
- Positive evidence presented upon a range of psycho-social outcomes and determinants
- No empirical research found examining SE as a mode of healthcare delivery
- More research is required to better understand and evidence causal mechanisms

Abstract

In recent years civil society organisations, associations, institutions and groups have become increasingly involved at various levels in the governance of healthcare systems around the world. In the UK, particularly in the context of recent reform of the National Health Service in England, social enterprise – that part of the third sector engaged in trading – has come to the fore as a potential model of state-sponsored healthcare delivery. However, to date, there has been no review of evidence on the outcomes of social enterprise involvement in healthcare, nor in the ability of social enterprise to address health inequalities more widely through action on the social determinants of health. Following the development of an initial conceptual model, this systematic review identifies and synthesises evidence from published empirical research on the impact of social enterprise activity on health outcomes and their social determinants. Ten health and social science databases were searched with no date delimiters set. Inclusion and exclusion criteria were applied prior to data extraction and quality appraisal. Heterogeneity in the outcomes assessed precluded meta-analysis/meta-synthesis and so the results are therefore presented in narrative form. Five studies met the inclusion criteria. The included studies provide limited evidence that social enterprise activity can impact positively on mental health, self-reliance/esteem and health behaviours, reduce stigmatization and build social capital, all of which can contribute to overall health and well-being. No empirical research was identified that examined social enterprise as an alternative mode of healthcare delivery. Due to the limited evidence available, we discuss the relationship between the evidence found and other literature not included in the review. There is a clear need for research to better understand and evidence causal mechanisms and to explore the impact of social enterprise activity, and wider civil society actors, upon a range of intermediate and long-term public health outcomes.

Introduction

The persistent and well-documented problem of health inequalities, preventable and unfair differences in health status between social groups, populations and individuals (Whitehead, 1992; Whitehead et al., 2001), has challenged public health researchers since the relationship between income and health was first established (Department of Health and Social Security, 1980; Townsend & Davidson, 1982). In the context of austerity measures leading to public-sector funding cuts and faced with continuing, even growing, inequalities, more innovative, community-based solutions have gained prominence (Baum, 2008; O'Mara-Eves et al., 2013). With this in mind, social enterprises – businesses with social objectives whose surplus revenue is reinvested for these purposes (Borzaga and Defourny, 2001; Dees, 1998; Defourny et al., 2014; Kerlin, 2009; Nyssens, 2006) – could prove to be a potentially innovative and sustainable response. However there is a significant gap in knowledge of how, and to what extent, social enterprise-led activity impacts upon health and well-being.

Furthermore, despite significant international policy attention in recent times, most obviously from the European Commission (as represented by, for instance, the recent Social Business Initiative) but also by the Obama Administration (the establishment of the Office of Social Innovation and Civic Participation and their Social Innovation Fund), there have been very few systematic reviews undertaken in the social enterprise/ social entrepreneurship/ social economy field in general. This is a notable absence, given that systematic reviews represent a cornerstone of the evidence-based practice and policy movement (Dixon-Woods et al., 2006).

Social enterprise as an alternative mode of delivery of state-sponsored healthcare has also had a significant amount of attention in recent years (Addicott, 2011; Cook, 2006;

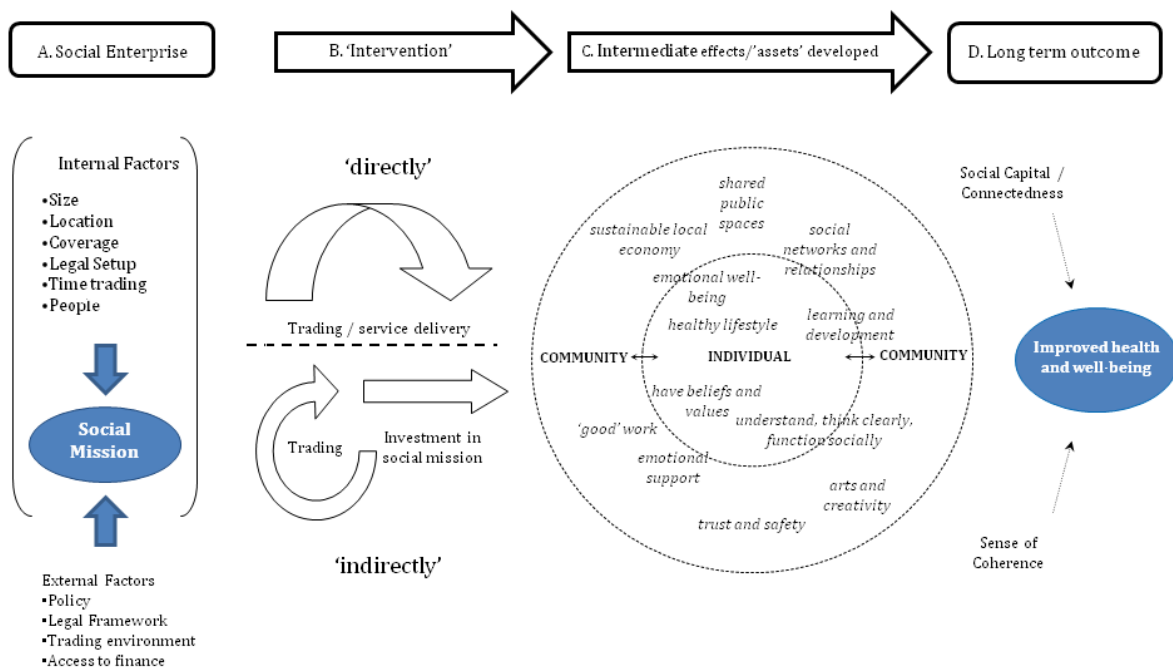
Dawes, 2009; Drennan et al., 2007; Harris, 2007; Roy et al., 2013), particularly in the UK, as private and third sector providers have been encouraged to enter into the healthcare quasi-market on the underlying assumption that they are capable of being more innovative and responsive than their public sector counterparts (Allen, 2009; Millar, 2012).

There have also been numerous examples of state-sponsored healthcare systems working in partnership with community-based organisations in an attempt to better impact upon individual risk factors including smoking, alcohol, diet and exercise. However, in the last couple of decades there has been a sustained call to re-orientate public health more closely towards “enabling the growth of what nourishes human life and spirit, and supporting life’s own capacity for healing and health creation” (Hanlon et al., 2011, p. 35) and the so-called ‘assets-based approach’ is one example of this type of thinking: building upon the potential strengths of individuals and communities (Morgan et al., 2010) rather than focusing on deficiencies (Foot, 2012; Foot & Hopkins, 2010; Kretzman & McKnight, 1993), with communities and outside agencies often working in partnership to ‘co-produce’ solutions (Brandsen & Pestoff, 2006).

If it is considered that social enterprise has the potential to be a viable and sustainable way of organising such activity (Donaldson et al., 2011; Roy et al., 2013, 2014) then a greater understanding of the health-enhancing mechanisms and causal pathways applied (or even assumed) in the work of social enterprises is undoubtedly required. To explain further, our hypothesis is that practically *all* social enterprises could be said, in one way or another, to impact upon such factors as the unequal distribution of power, income, goods, and services, all of which are established as important social determinants of health (Marmot et al., 2008; Wilkinson and Marmot, 2003). This is

described in Figure 1, in which we posit that a chain of causality exists from the trading activity of the social enterprise through to health and well-being of individuals and communities.

Figure 1: Conceptual model of social enterprise ‘intervention’



Of course, in reality, the sequence is unlikely to be either sequential or linear. The ability of the social enterprise to meet its social mission will likely be dependent upon a range of internal and extraneous factors. The social enterprise 'intervenes' either directly (i.e. the 'intervention' is the trading activity) or the trading activity generates profits which can then be invested in the types of 'assets' that we show in Part C of Figure 1. These examples, which are in no way intended to be exhaustive, are adapted from Cooke et al. (2011) and can be at the levels of individuals or communities, or both. As such, it is considered that the impact of such activity can be viewed through the lens of existing

theories, such as social capital/connectedness (Bourdieu, 1986; Coleman, 1988; Putnam, 2000) or Sense of Coherence (Antonovsky, 1987, 1979) as shown in Part D of the Figure, or by employing other theoretical frameworks, such as Capabilities (Nussbaum, 2011; Sen, 1985) which all have a body of evidence linking them to enhancements to individual and community health and well-being (see for example, Lomas (1998) and Uphoff et al. (2013) on social capital and Kivimäki et al. (2000) on Sense of Coherence).

Research Aims

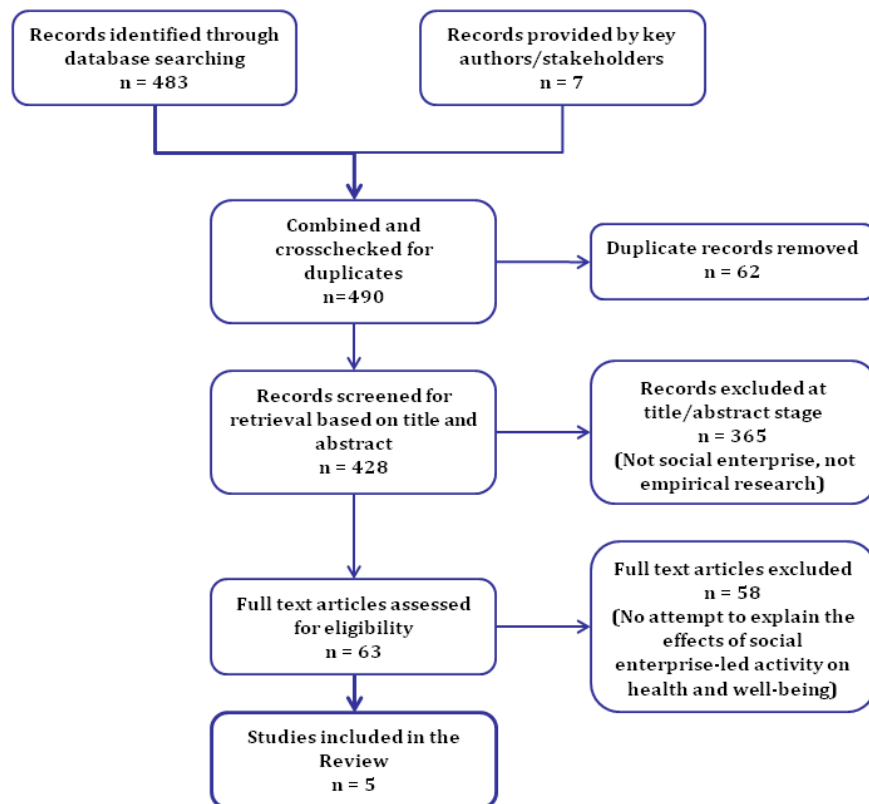
This paper offers two contributions to the debate on the social enterprise/health interface. First, we offer a systematic review of empirical evidence on this topic which is, as far as we are aware, the first such review undertaken in this area. Our second contribution relates to evidencing the potential of *any* social enterprise to be thought of as a predominantly ‘upstream’ (McKinlay, 1974, 1979; Williams et al., 2008) public health intervention, rather than as a mechanism for delivery of *healthcare* specifically. With social enterprise existing in many shapes and forms, varying impacts on health and well-being would be expected, and a major aim of our research agenda is to develop a theoretical framework, continually refining the conceptual model shown in Figure 1 through building evidence from empirical studies, for which this review is merely the starting point. Through this work it is hoped that we can support an advance in public health thinking and practice, particularly in relation to the role of social enterprise, the wider third sector, and other (perhaps non-obvious) actors in the future of public health.

Methods

We conducted searches of public health, social science and medical peer-reviewed journals in November and December 2012 using 10 different databases: ASSIA, CENTRAL, DARE, HMIC, IBSS, MEDLINE, PsycInfo, Sociological Abstracts, SSRN and Web of Knowledge. Each search used a combination of words related to social enterprise and predecessor concepts (social enterprise, social business, social entrepreneur, social firm, community enterprise, community business and affirmative business) and to health related quality of life. This included both psycho-social factors (such as sense of coherence, social capital, self-esteem, capabilities, hope for the future, self-reported well-being, happiness) and socio-economic factors (such as income, occupation, education, and literacy). Searches were not restricted by publication date. Key authors, identified during the course of the database searches and through our own personal contacts, were also approached and asked to send on articles for consideration, and further justification for this approach is provided in the Discussion section below. We identified 490 papers: 483 from database searches and seven sent us by key authors. Sixty two were found to be duplicates and removed. Titles and abstracts were initially screened for relevance and 365 were excluded at that stage. The full texts of the remaining 63 studies were then reviewed independently by two authors according to the following criteria: (1) published in English; (2) empirical research on social enterprise-led activity on health and well-being. Case studies, clinical reports, policy documents and discussion/opinion papers were excluded. Where disagreements arose, the reviewers met to discuss and resolve (and a third party would have been brought in if there was still disagreement.) Following these steps, seven articles met the inclusion criteria. Three were combined (i.e. Ferguson & Islam, 2008; Ferguson, 2012, 2013) as

they reported on findings from the same study group. The total number of separate studies discussed, as shown at Figure 2, is therefore five.

Figure 2: Results of the search and study selection process.



A review-specific data extraction tool was developed, tested and refined to capture a range of data to assist in the synthesis. For each study the following information was collected: author(s) and year of publication; type of ‘intervention’ and its theoretical underpinnings; participants; study design; sampling procedure; data collection; sample size; the methodological perspective/analytical approach employed in the study; and a brief summary of the key findings.

Each paper was also assessed by two reviewers separately on a range of quality criteria based upon Popay (2006): whether the aims and objectives were clearly stated and addressed; the discussion of the context and need for the study (i.e. the justification for

the study); whether there was a clear description and appropriateness of the sampling strategy and method of recruitment presented; the description of the intervention (including theoretical and underpinnings and any comparator/control interventions); whether there was a clear description and appropriateness of methods used to collect and analyse data; the attempts made to establish the reliability and validity of quantitative data and the credibility of qualitative data (i.e. the rigour of the process) and; whether there was inclusion of sufficient original data to mediate between evidence and interpretation. No papers were discounted on grounds of quality, but, for the sake of validity or credibility (Lincoln & Guba, 1985) it was deemed important to provide some commentary of the studies in terms of their quality. Each of the seven quality elements was rated at between 0 and 2. A quality rating of 'High' meant a score between 10 and 14, 'Moderate' between 5 and 9, and 'Low', a score of between 0 and 4. These ratings are not intended to be definitive by any means: they are simply presented to facilitate the interpretation of the findings. Due to the variety of measures and study designs employed across studies it was not possible to perform a meta-analysis or meta-ethnography and so narrative synthesis (Popay et al., 2006) has been employed. An example of a database search with the full range of search terms employed and the breakdown of the quality assessment of the papers are both available as (online) supplementary files.

Results

Findings from the five separate studies that met the inclusion criteria are summarised in Table 1. The earliest study was published in 2003 and the remainder between 2008 and 2013. Four of the five studies focused upon a specific type of social enterprise known variously as a social firm, an affirmative business, or a Work Integration Social

Enterprise (WISE). All of these terms relate to a specific type of social enterprise that has workforce development and/or job creation for disadvantaged populations as its core purpose (Krupa et al., 2003; Lysaght et al., 2012; Spear and Bidet, 2005; Vidal, 2005; Warner & Mandiberg, 2006) and may also combine a mission to address social exclusion (Teasdale, 2010, 2012) with providing a product or service needed by society (Ferguson, 2012). No empirical research was identified which examines social enterprise as an alternative mode of healthcare delivery.

As can be seen from Table 1, only one of the studies was rated as being of 'high' quality, three were rated as 'moderate' and one as 'low' quality. One of the studies was undertaken in the US, two in Australia, one in Canada and one in Hong Kong. All five of the studies employed qualitative methods with two (Ferguson, 2012, 2013; Krupa et al., 2003) employing mixed methods. As is often the case with qualitative studies, sample sizes were low, ranging from five people (Ferguson & Islam, 2008) to seven people (Williams et al., 2010) to 32 people (Krupa et al., 2003) to 51 organisations (Ho and Chan, 2010) while one study did not specify their sample size (Tedmanson and Guerin, 2011). In the two studies that also employed quantitative components, one used the responses of 16 individuals compared with a control group also of 16 people (Ferguson, 2012, 2013) matched as far as possible on age, race and gender, while the other (Krupa et al., 2003) utilised survey responses from 73 individuals.

Table 1: Summary of included studies.

Paper (year) and country	Type of SE 'Intervention'	Theoretical underpinning of 'intervention'	Aimed at	Study Design/ Data Collection	Sampling Procedure	Sample Size	Methodological perspective/ analytical approach	Brief Summary of key findings	Quality Assessment
Ferguson & Islam (2008) Ferguson (2012, 2013) US	Social Firm/WISE	<p>Draws on asset-based youth development and thriving. Specifically, youths' internal developmental assets are categorized in four areas: commitment to learning, social competencies, positive values and positive identity.</p> <p>Collectively, the social enterprise intervention (SEI) components aim to strengthen the youths' internal assets to enhance positive outcomes and protect them against high risk behaviour.</p>	Street-living young adults	Mixed methods design incorporating: (1) Qualitative study based on focus-group interviews (2) quantitative (survey) component delivered via structured interview	<p>(1) Purposive sampling of participants who 'remained with the programme'</p> <p>(2) Two screening criteria guided recruitment: (1) the youths had to have attended the Agency two or more times a week for the month prior to the study; and (2) the youths had to commit to attending the programme for both the 4 month vocational and business training programmes. A separate control group was formed in the agency and an attempt was made to match the groups on age, gender and ethnicity.</p>	<p>(1) 5</p> <p>(2) 16 (SEI) and 16 (Control Group)</p>	<p>(1) Constructivist Grounded Theory, Constant comparison methods</p> <p>Investigator, theory and data triangulation methods</p> <p>(2) <i>Satisfaction with life</i> was assessed using the Satisfaction with Life Scale.</p> <p><i>Family support</i> measured the frequency with which the youth reported that they see, write, or talk to their immediate family.</p> <p><i>Peer support</i> was a composite variable of the sum of four items on the Friends Subscale of the Adult Self Report.</p> <p><i>Depression</i> was assessed using the Reynolds Depression Screening Inventory.</p>	<p>Mental Health: family respect; self-esteem and motivation; goal orientation</p> <p>Employment outcomes: Acquisition of knowledge and skills, increased exposure to the world of work.</p> <p>Service Related Outcomes: relationship with staff; service engagement; social networks</p> <p>Behavioural Outcomes: respite from street life; avoidance of destructive behaviour</p> <p>Societal outcomes: positive aspects of homeless; image with authorities</p> <p>Satisfaction with life: A 6.45-unit increase in total life satisfaction from baseline to the end of follow-up, compared with a 2.25-unit decrease in the control group ($P = .02$)</p> <p>Family support: 0.50-unit increase in family support over the study period, as compared to a 1.20-unit decrease observed in the control group ($P = .03$)</p> <p>Peer support: 3.00-unit increase in peer support over the study period, whereas the control group experienced a 0.13-unit increase ($P = 0.06$)</p> <p>Depression: 5.45-unit decrease in depressive symptoms, compared with no change observed in the control group ($P = 0.10$)</p>	High
Ho & Chan (2010) Hong Kong	Work Integration Social Enterprise (WISE)	WISEs help people move from welfare dependency to self-reliance by giving them the capacity for independent wage-earning.	A range of disadvantaged groups: people with disabilities, new immigrants,	Case study approach: qualitative research method characterized by selective	Purposive sampling of WISEs in Hong Kong, representing a wide range of business activities and target populations.	51 WISEs	Constant comparison Investigator triangulation	Because the target groups and the modes of intervention are so heterogeneous, there is no unified set of outcomes presented. There are outcomes drawn from specific examples e.g. 40% of participants no longer reliant upon social security, about half becoming	Moderate

		As well as those related to job outcomes (learning new job skills, enhancing employability and moving out of poverty) reduction in the public stigmatization of marginalized groups and building social capital are also target "social goals".	the elderly, unemployed youths, ex-offenders and low-income families	sampling and in-depth examination using semi-structured interviews				employable in the open market, which increases their opportunity to increase their and "resume their dignity". WISEs address the issue of social exclusion in the labour market People gain better employability and thus the opportunity to move from welfare to self-reliance. WISEs facilitate the building of social capital among their employees. WISEs cultivate a self-help spirit and a sense of belonging among marginalized groups in poor neighbourhoods, and become a means through which they expand their social and supportive networks and cooperate with each other for mutual benefit on the basis of trust. For persons with disabilities, WISEs also enhance job satisfaction, facilitate the realization of their potential and expedite the progress of recovery. For socially stigmatized groups like people with mental health problems and ex-offenders, WISEs improve mutual understanding and interaction with the community, and hence facilitate social recognition and a supportive social environment for social integration.	
Krupa et al. (2003) Canada	'Affirmative business' aka WISE/social firm	Examines the outcomes associated with an organisation which used the resources of a sheltered workshop in a provincial psychiatric hospital to evolve affirmative businesses/social firms for people receiving mental health services. Unlike vocational rehabilitation efforts that focus on	Owners/operators with psychiatric disabilities	A three stage approach was taken which employed: (1) analysis of historical and accounting records and interviews with former participants in sheltered workshops; (2) a survey of people who decided not to be involved in the	(1) not specified (2) all people who had decided in the past not to be involved were invited to complete a survey in an attempt to identify a comparator group (3) Sampling procedure for choosing owner/operators was not specified	(1) Not specified (2) 73 surveys (3) 32 people	Straussian data analysis, data coding and axial coding to identify key themes, associations between themes and causal conditions. Investigator / data triangulation methods	Success of the approach was evaluated by both the economic sustainability of businesses and the wellbeing of the 'consumer community'. Measures of well-being included (1) increased employment opportunities; (2) increased level of personal involvement and ownership; (3) improvement in living conditions; and (4) meeting or exceeding standards for fair employment	Moderate

		helping individuals to “fit in” to the existing employment market, affirmative businesses use a community economic development approach to neutralize labour force conditions of individualism, competition and profit that perpetuate employment disadvantage.		programme; and (3) a series of semi-structured focus groups of owner/operators and business support staff					
Tedmanson & Guerin (2011) Australia	Social enterprise generally	Based upon “strengths-based” approaches to community development, which emphasizes the social capital assets of communities, aim to reinforce local talents, and build local capacity.	“Remote” indigenous Australian community contexts	Interviews and participant observation	Not specified	Not specified	Not specified	Enhancements in interdependence and independence. Concomitant mental health and social wellbeing dividends accrue over time to communities engaged in self-determined enterprise activities. Social entrepreneurship builds social capital that supports social wellbeing. Strengths-based approaches to social entrepreneurship can assuage disempowering effects of welfare through shifting the focus onto productive activities generated on people’s own terms.	Low
Williams et al. (2010) Australia	Social Firm/WISE	Ongoing, secure employment provides pathways to economic participation, social inclusion and recovery. Social firms or enterprises aim to offer sustainable employment in supportive workplaces for people who are	Employees with psychiatric disabilities	Interviews using the Work Environment Impact Scale (Version 2.0). Interviews were audiotaped, transcribed and analysed inductively using thematic and narrative analysis.	Adults experiencing psychiatric disability; comfortable conversing in English; and employed for 6 months or longer in the social firm.	7 people	The WEISv2.0 is designed specifically to explore a worker’s perception of the work environment through questions about physical and social workplace factors that may have a positive or negative impact on the worker.	The participants perceived rewards, interactions with others, work schedules and task demands at the social firm positively. The participants sustained their employment because they perceived that their jobs were different to other jobs: the social firm offered secure employment; supportive and inclusive work relationships; and regular schedules and tasks that participants believed they could complete well, leading to high levels of job satisfaction. Further, the workers perceived that	Moderate

		disadvantaged in the labour market.						working at the social firm benefited their emotional and physical wellbeing, specifically contributing positively to their health, economic circumstances and occupational life-course.	
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To aid understanding of our synthesis of the health and well-being outcomes presented in the studies, these are presented in three categories: physical health, mental health and social determinants. In reality, of course, these categories are interrelated: they impact upon and reinforce each other.

Physical health

One of the studies (Ferguson & Islam, 2008) explicitly provided qualitative evidence that working in the social enterprise was a viable mechanism to encourage participants not to engage in the types of destructive or illicit behaviours known to be detrimental to physical health. Another study (Williams et al., 2010) presented limited qualitative evidence of a perception that working at the social enterprise benefited participants' physical wellbeing.

Mental Health

All five of the studies (Table 1) presented evidence that the participants experienced several positive mental health changes as a result of their involvement with the social enterprise. It was found that, if participants had continued relationships with their family, then participation in such a goal-focused vocational training programme would lead to increased feelings of familial respect and sense of self, particularly in relation to their accomplishments (Ferguson & Islam, 2008). Furthermore, the studies presented a range of evidence which stated that social enterprises can enhance non-vocational outcomes such as self-confidence or self-esteem (Ferguson & Islam, 2008; Ho & Chan, 2010; Williams et al., 2010) and motivation and commitment to goals/life direction (Ferguson & Islam, 2008; Krupa et al., 2003). It was reported in three of the studies (Ferguson & Islam, 2008; Krupa et al., 2003; Williams et al., 2010) that the social

enterprise work environment helped the participants to feel calm and relaxed, so that, for instance, they were better able to express their ideas (Ferguson & Islam, 2008).

The only quantitative analysis undertaken (Ferguson, 2012, 2013) on mental health outcomes used four indicators: *satisfaction with life, family support, peer support* and *depression*, all of which were positively impacted in comparison to a control group. The studies suggested too that the social enterprise enabled people with mental health problems to fulfil their desire “to participate in meaningful occupation” (Williams et al., 2010, p. 536) and limited depressive symptoms through “providing the financial incentive to participate in activities that hold meaning and give direction and structure” (Krupa et al., 2003, p. 363) and demonstrated that, for employees with psychiatric disabilities, working in such an environment made them feel better, kept them healthy and prevented boredom (Krupa et al., 2003).

Social Determinants

All five studies, as Table 1 indicates, referred to the social determinants of health in some way. Indeed, two of them (Ferguson & Islam, 2008; Tedmanson & Guerin, 2011) explicitly drew upon theories regarding ‘assets’ (specifically asset-based youth development and thriving (Benson et al., 1999; Benson, 2003) in the former) or ‘strengths’ to explain the role of social enterprise as a mechanism for sustainably helping to generate or preserve the factors that influence upon individual and community health and well-being. All five studies, for instance, emphasised in various ways the enhancement of knowledge and skills as being of key importance to enhancing employability, and, indeed, to helping people to maintain and find a job in future. The social enterprise served as a “springboard” (Ho & Chan, 2010, p. 38) or “stepping-stone” (Krupa et al., 2003, p. 362) to employment through providing on-the-job training which

increased the chance of employment down the line, or which assisted people to become self-employed, with the aim to facilitate the integration of disadvantaged groups into both the job market and the community and “resume their dignity” (Ho & Chan, 2010, p. 40). Two of the five studies (Ferguson & Islam, 2008; Ho & Chan, 2010) reported that a key outcome was a reduction in the public stigmatization of marginalized groups, such as people living on the street, people with mental health problems, or ex-offenders: it was found that social enterprises “provide a window of opportunity for mutual understanding and interaction with the community, and hence facilitate social recognition and a supportive social environment for social integration” (Ho & Chan, 2010, p. 41) and play a critical role in reducing public stigmatization by demonstrating that members of marginalized groups can be capable, productive workers and members of society. Three of the five studies (Ferguson, 2012; Ho & Chan, 2010; Tedmanson & Guerin, 2011) specifically mentioned that social enterprises were a mechanism for building social capital, providing an opportunity for disadvantaged and marginalized groups to expand their social networks and develop social trust, facilitating social trust and co-operation, strengthening their existing peer support groups, and enhancing their future career prospects.

Discussion

Our systematic review of the empirical evidence presently available on the interface between health and social enterprise has revealed that there is currently no available evidence from which to assess social enterprise as an alternative mechanism for healthcare delivery in comparison with any other model. That they are capable of being more innovative and responsive than their public sector counterparts, at least in the health arena, remains simply an assumption in the absence of any supporting or

refuting evidence. The heterogeneity of the outcomes explored and the fact that much of the data is qualitative limits what can be said about the effectiveness of social enterprise as a public health intervention. Nevertheless, it is important that a systematic approach was taken as it provides clear evidence of the current very limited evidence base and the need for quantitative studies to explore effectiveness and qualitative studies to explore mechanisms of action. There are a limited number of common lessons that can be drawn from the studies reviewed more-formally here, but also from the wider literatures on social enterprise and public health. We set these out briefly with a view to contributing to a future research agenda in this area.

Common lessons from the review

The evidence suggests that Work Integration Social Enterprises/Social Firms may be a good model for supporting people disadvantaged from the labour market and that there are a range of advantages, at a number of different levels, both to the participants and to wider society. Social enterprises can impact in various ways upon health: they can be a good mechanism for enhancing skills and employability, which leads to increased self-reliance and esteem, they can reduce stigmatization, particularly of marginalized groups, and they can work to build social capital and improve health behaviours, all of which can contribute to overall health and well-being. While the heterogeneity of the study designs, the varying quality of the studies, the low sample sizes used and the very specific contexts in which the studies took place all make generalisable claims difficult, by bringing these factors together, they can help to inform future hypotheses and theoretical development.

The second aim of our review was to build upon and refine our initial hypothesis around the potential of *any* social enterprise to be thought of as a predominantly

‘upstream’ intervention. The limited evidence presented in this review shows that social enterprises can work to maintain and build the types of ‘assets’ that we show in Part C of Figure1, although patently there is a need for many more empirical studies involving more people in more settings, and covering a wider range of research methods, including quantitative comparative evaluations. Hopefully, such future empirical work can be informed by the methodological strengths and limitations of the studies that we identified in this review.

Supplementary literature from social enterprise

By employing an integrative approach (Whittemore & Knafl, 2005) it has been possible to provide a narrative synthesis of a wide range of study types, offering a comprehensive overview of the available published evidence. However, it is, of course, possible that not all of the relevant literature has been captured. Our strategy to broaden the reach of the electronic searches involved contacting the handful of researchers across the world with published work in the social enterprise/health interface and presenting our initial findings at conferences. This led us to a small body of interesting and relevant work that fell just outside the scope of this review, notably the work of Pestoff (2000) on the psycho-social work environment within social co-operatives in the Swedish care sector and related work, also undertaken in Sweden, by Stryjan (1995). It also led us to more recent work by Bertotti et al. (2012) on social enterprises as instruments for building social capital in disadvantaged areas of London, work by Barraket (2013) on the impact of WISEs upon immigrants and refugees in the Australian state of Victoria, recent work by Farmer et al. (2012) on the role of social enterprise as a means of addressing disadvantage in remote and rural communities and work by Teasdale (2010) on social enterprise as a means of addressing social exclusion

in inner city communities. This small body of additional literature, although it has not been subject to the same level of rigorous analysis as the other papers identified, broadly supports the plausibility of the findings and conceptualisations presented herein.

Despite much being made of the importance of social enterprise to aid development, and as a mechanism to alleviate poverty (Cooney & Williams Shanks, 2010; Yunus, 2009) all of the studies identified in the review took place in so called 'advanced' economies, and none from developing countries. Even within advanced economies, the absence of studies from Europe was a particular surprise, particularly given strong traditions of social enterprise activity there, notably the work of Italian social co-operatives (Borzaga & Depedri, 2013; Borzaga & Galera, 2012; Mancino & Thomas, 2005) which emerged at the end of the 1970s, mainly on the initiative of a small groups of volunteers and workers who were dissatisfied by poor provision of social and community care services.

One can also come at this issue from the point of view of those who see social enterprise as one response to the excesses of the unfettered market, which have exacerbated and accelerated health inequalities (Mooney, 2012; Scambler, 2007). Here, social enterprise could be seen as a means of 're-embedding' the market (Polanyi, 1944) so that it is seen as simply one of three 'poles' of the economy (i.e. state, market and community). The social enterprise acts as a 'hybrid' (Defourny & Nyssens, 2006) form of organisation that works across and between these three 'poles,' not limited to the market principle of exchange or the principle of redistribution, but which also takes account of the principle of reciprocity (Gardin, 2006) which means that social enterprises are able to draw upon a plurality of resources and mobilize different kinds of market and non-market

resources to sustain their goals. The social purpose, therefore, “to contribute to the welfare of well-being in a given human community” (Peredo and McLean, 2006, p. 59) is not a consequence, or a side-effect, of economic activity, but its *motivation* (Defourny and Nyssens, 2006).

Furthermore, social enterprises (at least in mainstream conceptualisations) are, at their heart, community-based organisations: their roots are to be found in places, communities of interest, or what Mandiberg describes as ‘enclave communities’ (Mandiberg, 2010). The concept of ‘story’, the personal narratives of people’s everyday lives, is integral to their success, as the first chapter of John Pearce’s seminal text *Social Enterprise in Anytown* so aptly demonstrates (Pearce, 2003, pp. 8–23). Attending to personal narratives can help orient occupational therapists, case managers in mental health services and vocational service providers towards providing support and advocacy, to start to address barriers that limit their clients’ career development (Williams et al., 2012) such as addressing inflexible benefit systems or a lack of supported education and training opportunities, all of which may have important health effects.

Supplementary literature from public health

As we said in our introduction, for some time now conceptualizations of health and well-being have been shifting away from a focus on individual pathologies and risk factors towards a greater awareness of the importance of social relationships, community processes and social contexts in producing health and well-being. The so-called ‘Fifth Wave’ of thinking in public health (Hanlon et al., 2011) owes its origins to several decades of debate and attempts to reconfigure practice, and the recent policy attention on ‘assets-based’ approaches is only the latest policy manifestation of such

thinking. It is clear, however, that new conceptualisations of what a public health intervention could or should look like in this (still evolving) paradigm are required. Social enterprise could present a number of benefits, at multiple levels, to 'operationalise' such Fifth Wave thinking, particularly as a means of building social capital and assets such as self-esteem and self-reliance in a sustainable – at least in theory – fashion.

It could be envisaged that “many of the key players [of the Future Public Health] may not consider themselves to be involved formally in public health at all: their influence on health will be a product of their primary intent” (Hanlon et al., 2012, p. 169) but while there may not have been a great deal of empirical research undertaken from a 'Fifth Wave' standpoint, which is just starting to penetrate the consciousness of public health researchers, over the last couple of decades we have seen a number of large-scale flagship programmes, such as the WHO Healthy Cities Programme, and the UK Government's Sure Start Programme, which have attempted to act upstream. Healthy Cities, established formally in 1987, was one of the first major initiatives following the Ottawa Charter for Health Promotion in 1986 and one of its core principles was the broadening of the scope of public health actors to include those that would not be termed immediately obvious e.g. third sector organisations and local authority departments not chiefly responsible for health (Tsouros, 1995). Evelyn De Leeuw, who has published extensively on the Healthy Cities programme, recognised back in 1999 that social entrepreneurs would be “vital for the future development of health promotion, as they offer a way of tackling the social determinants of health and disease through community-based action” (De Leeuw, 1999, p. 261) before the terms 'social enterprise' or 'social entrepreneurship' were even being talked about to any meaningful

extent in an academic context. Sure Start, on the other hand, aimed to act upon the vital early years in a child's development through improvement of childcare, early education, health and family support, and, it has been argued, explicitly as an upstream intervention on health inequalities (Gidley, 2007). Many social enterprises have been involved as providers of local Sure Start services, and this programme acted as a catalyst for a large number of new social enterprises being started in the UK (France, 2007). Both of these initiatives, and many more throughout the world, have contributed to our knowledge of what 'focusing upstream' entails, and the potential, in public health terms, of doing so.

The future research agenda

The evidence presented in this review suggests that the potential of social enterprise and other civil society actors to work in such a way requires continued theoretical and conceptual development and – crucially – further empirical work to help inform and test initiatives that may arise from such thinking. In particular, this review has identified that a clear gap in knowledge exists regarding the causal mechanisms at work, through which social enterprises and other civil society actors seek to impact upon a range of intermediate and long-term public health outcomes. In recognition of this gap, a five-year programme of research to evidence the impact of 'social enterprise as a public health intervention' has been funded jointly by the UK's Medical Research and Economic and Social Research Councils, which commenced in January 2014 (Glasgow Caledonian University, 2013).

It is incumbent upon Governments, particularly in advanced economies, to seek a way out of the cycle of diminishing returns from investment into public healthcare systems, to bridge the 'ingenuity gap' (Homer-Dixon, 2000) between the problems we face and

the availability of adequate solutions. Social enterprises, with their emphasis upon reinvesting profits into the community towards achieving a social mission, *may well* present such a potential, community-based, solution, but one which requires equally-sophisticated research evidence to inform its development and support in such a role. In turn, this may help convince Governments of the health and well-being merits, or otherwise, of subsidising and regulating to help provide an enabling and supportive environment in which community-led social enterprises can prosper.

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